

		FOR BHF USE					

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2005  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2005)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0033977</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>																																																																																					
<b>Facility Name:</b> <u>Atrium Health Care Center</u>		<p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/05</u> to <u>12/31/05</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p>																																																																																					
<b>Address:</b> <u>1425 West Estes Avenue</u> <u>Chicago</u> <u>60626</u>																																																																																							
<div>NumberCityZip Code</div>																																																																																							
<b>County:</b> <u>Cook</u>																																																																																							
<b>Telephone Number:</b> <u>(773) 973-4780</u> <b>Fax #</b> <u>(773) 973-1895</u>																																																																																							
<b>HFS ID Number:</b> <u>363589582001</u>		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Type or Print Name) _____</td><td></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Title) _____</td><td></td></tr><tr><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Richard S. Sgarlata, C.P.A.</u></td><td></td></tr><tr><td>(Firm Name &amp; Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td><td></td></tr><tr><td colspan="2" rowspan="2"><b>Date of Initial License for Current Owners:</b> <u>00/00/88</u></td><td colspan="2">(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td></tr><tr><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr><tr><td colspan="2"><b>Type of Ownership:</b></td><td colspan="2"></td></tr><tr><td colspan="2"><table><tr><td><input type="checkbox"/></td><td>VOLUNTARY, NON-PROFIT</td><td><input checked="" type="checkbox"/></td><td>PROPRIETARY</td><td><input type="checkbox"/></td><td>GOVERNMENTAL</td></tr><tr><td><input type="checkbox"/></td><td>Charitable Corp.</td><td><input type="checkbox"/></td><td>Individual</td><td><input type="checkbox"/></td><td>State</td></tr><tr><td><input type="checkbox"/></td><td>Trust</td><td><input type="checkbox"/></td><td>Partnership</td><td><input type="checkbox"/></td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td><input type="checkbox"/></td><td>Corporation</td><td><input type="checkbox"/></td><td>Other _____</td></tr><tr><td colspan="2"></td><td><input checked="" type="checkbox"/></td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>Other</td><td colspan="2">_____</td></tr></table></td><td colspan="2"></td></tr><tr><td colspan="2"><b>In the event there are further questions about this report, please contact:</b></td><td colspan="2"></td></tr><tr><td colspan="2"><b>Name:</b> <u>Steve Lavenda</u> <b>Telephone Number:</b> <u>(847) 236 - 1111</u></td><td colspan="2"></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) _____		Paid Preparer	(Title) _____		(Signed) _____	(Date) _____	(Print Name and Title) <u>Richard S. 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SEE ACCOUNTANTS' COMPILATION REPORT

#	0033977	Report Period Beginning:	01/01/05	Ending:	12/31/05
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**D. How many bed-hold days during this year were paid by the Department?**

**None** (Do not include bed-hold days in Section B.)

**E. List all services provided by your facility for non-patients.**  
**(E.g., day care, "meals on wheels", outpatient therapy)**  
**None**

**F. Does the facility maintain a daily midnight census?** Yes

YES ☐ NO ☒

YES ☐ NO ☒

**Date started** 07/01/88

YES ☒ Date 07/01/88 NO ☐

YES ☒ NO ☐ If YES, enter number

of beds certified	20	and days of care provided	1,416
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**Medicare Intermediary      Mutual Of Omaha**

ACCRUAL	<input checked="" type="checkbox"/>	MODIFIED	<input type="checkbox"/>	CASH*	<input type="checkbox"/>
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Is your fiscal year identical to your tax year? YES ☒ NO ☐

**\* All facilities other than governmental must report on the accrual basis.**

## SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Atrium Health Care Center      #      0033977      Report Period Beginning:      01/01/05      Ending:      12/31/05

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	240,284	49,807	13,743	303,834		303,834		303,834			1
2	Food Purchase		201,085		201,085	(31,726)	169,359	(23)	169,337			2
3	Housekeeping	216,234	38,778		255,012		255,012		255,012			3
4	Laundry	65,044	12,401		77,445		77,445		77,445			4
5	Heat and Other Utilities			128,546	128,546		128,546	2,097	130,643			5
6	Maintenance	35,125	16,588	39,084	90,797		90,797	8,426	99,223			6
7	Other (specify):*							963	963			7
8	<b>TOTAL General Services</b>	556,687	318,659	181,373	1,056,719	(31,726)	1,024,993	11,463	1,036,456			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			11,050	11,050		11,050		11,050			9
10	Nursing and Medical Records	1,499,616	61,215	24,141	1,584,972		1,584,972	(13,298)	1,571,674			10
10a	Therapy	45,514		320	45,834		45,834		45,834			10a
11	Activities	59,905	3,451	1,947	65,303		65,303		65,303			11
12	Social Services	80,608		3,922	84,530		84,530		84,530			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	1,685,643	64,666	41,380	1,791,689		1,791,689	(13,298)	1,778,391			16
	<b>C. General Administration</b>											
17	Administrative	85,247		244,800	330,047		330,047	(138,813)	191,234			17
18	Directors Fees											18
19	Professional Services			56,473	56,473		56,473	2,426	58,899			19
20	Dues, Fees, Subscriptions & Promotions			49,776	49,776		49,776	(23,566)	26,210			20
21	Clerical & General Office Expenses	30,167	49,230	28,568	107,965		107,965	25,579	133,544			21
22	Employee Benefits & Payroll Taxes			379,640	379,640	31,726	411,366		411,366			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,481	2,481		2,481	244	2,725			24
25	Other Admin. Staff Transportation			2,813	2,813		2,813	774	3,587			25
26	Insurance-Prop.Liab.Malpractice			149,618	149,618		149,618	2,575	152,193			26
27	Other (specify):*							33,215	33,215			27
28	<b>TOTAL General Administration</b>	115,414	49,230	914,169	1,078,813	31,726	1,110,539	(97,566)	1,012,972			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,357,744	432,555	1,136,922	3,927,221		3,927,221	(99,401)	3,827,820			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			23,617	23,617		23,617	57,842	81,459			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,708	3,708		3,708	86,986	90,694			32
33	Real Estate Taxes			187,162	187,162		187,162	8,589	195,751			33
34	Rent-Facility & Grounds			564,000	564,000		564,000	(564,000)	(0)			34
35	Rent-Equipment & Vehicles							7,111	7,111			35
36	Other (specify):*							9,533	9,533			36
37	<b>TOTAL Ownership</b>			778,487	778,487		778,487	(393,940)	384,547			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		51,319	91,321	142,640		142,640		142,640			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			87,600	87,600		87,600		87,600			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		51,319	178,921	230,240		230,240		230,240			44
	<b>GRAND TOTAL COST</b>											
45	(sum of lines 29, 37 & 44)	2,357,744	483,874	2,094,330	4,935,948		4,935,948	(493,341)	4,442,607			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(61,435)	30		9
10	Interest and Other Investment Income	(7,726)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(23)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(15,509)	21		24
25	Fund Raising, Advertising and Promotional	(15,710)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(5,863)	20		28
29	Other-Attach Schedule	(45,945)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (152,211)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(341,130)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (341,130)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (493,341)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS			Page 5A
Atrium Health Care Center			
ID# 0033977			
Report Period Beginning:	01/01/05		
Ending:	12/31/05		
			Sch. V Line
NON-ALLOWABLE EXPENSES			
	Amount	Reference	
1 Replacement Income Tax	\$ (14,927)	21	1
2 Pharmacy - VA	(13,286)	10	2
3 Miscellaneous Income	(3,688)	21	3
4 Parking Income	(4,475)	32	4
5 Non-Allowable Legal	(78)	19	5
6 C/PPE	(3,273)	20	6
7 2000 Seminars	(380)	24	7
8 Building Partnership Illinois Replacement Tax	(3,614)	21	8
9 Capitalized R&M	(2,816)	06	9
10 Non-Allowable Auto	(1,407)	25	10
11			11
12			12
13			13
14			14
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96			96
97			97
98			98
99			99
100			100
101 Total	(45,940)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/05 Ending: 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary													1
2	Food Purchase	(23)											(23)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			2,097									2,097	5
6	Maintenance	(2,816)		3,485	7,757								8,426	6
7	Other (specify):*				963								963	7
8	<b>TOTAL General Services</b>	<b>(2,839)</b>		<b>5,582</b>	<b>8,720</b>								<b>11,463</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(13,298)											(13,298)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(13,298)</b>											<b>(13,298)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(214,967)	76,154								(138,813)	17
18	Directors Fees													18
19	Professional Services	(70)		2,098		398							2,426	19
20	Fees, Subscriptions & Promotions	(23,846)		280									(23,566)	20
21	Clerical & General Office Expenses	(36,735)	3,614	58,656		44							25,579	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(380)		624									244	24
25	Other Admin. Staff Transportation	(1,407)		2,181									774	25
26	Insurance-Prop.Liab.Malpractice			1,949		626							2,575	26
27	Other (specify):*			28,294	4,921								33,215	27
28	<b>TOTAL General Administration</b>	<b>(62,438)</b>	<b>3,614</b>	<b>(120,885)</b>	<b>81,075</b>	<b>1,068</b>							<b>(97,566)</b>	<b>28</b>
	<b>TOTAL Operating Expense</b>													
29	<b>(sum of lines 8,16 &amp; 28)</b>	<b>(78,575)</b>	<b>3,614</b>	<b>(115,304)</b>	<b>89,795</b>	<b>1,068</b>							<b>(99,401)</b>	<b>29</b>





VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Atrium Healthcare LTD Partnership Bldg Co.		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	\$ 564,000	Atrium Healthcare Ltd. Partnership		\$	(564,000)	1
2	V	32	Mortgage Interest				91,528	91,528	2
3	V	30	Depreciation				114,375	114,375	3
4	V	36	Amortization				9,533	9,533	4
5	V	21	Illinois Replacement Tax				3,614	3,614	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 564,000			\$ 219,050	\$ * (344,950)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ X

 YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	STAYCARE MANAGEMENT, LTD.	100.00%	\$ 2,097	\$ 2,097	15
16	V	6	REPAIRS AND MAINT.				3,485	3,485	16
17	V	17	ADMIN. SAL.-NON OWNER				29,833	29,833	17
18	V	19	PROFESSIONAL FEES				2,098	2,098	18
19	V	20	DUES, SUBSCRIPTIONS				280	280	19
20	V	21	CLERICAL & GENERAL				58,656	58,656	20
21	V	24	SEMINARS				624	624	21
22	V	25	ADMIN. STAFF TRAVEL				2,181	2,181	22
23	V	26	INSURANCE				1,949	1,949	23
24	V	27	EMPLOYEE BENEFITS				28,294	28,294	24
25	V	32	INTEREST				398	398	25
26	V	34	BUILDING RENT				21,228	21,228	26
27	V	35	EQUIPMENT RENTAL				7,111	7,111	27
28	V								28
29	V	17	Mgmt Fees	244,800	STAYCARE MANAGEMENT, LTD.			(244,800)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 244,800			\$ 158,233	\$ * (86,567)	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIET. COMP - S. WEBSTER	\$	STAY CARE MANAGEMENT, LTD.	100.00%	\$		15
16	V	6	MAINT. COMP. - NON-OWNER				7,757	7,757	16
17	V	7	EMP. BEN. - S. WEBSTER						17
18	V	7	EMP. BEN. - MAINT. NON-OWNER				963	963	18
19	V	17	ADMIN. COMP - H. WENGROW				12,692	12,692	19
20	V	17	ADMIN. COMP - J. WEBSTER				63,462	63,462	20
21	V	27	EMP. BEN. - H. WENGROW				828	828	21
22	V	27	EMP. BEN. - J. WEBSTER				4,093	4,093	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 89,795	\$ * 89,795	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	\$	DOUBLE YOU REALTY, LLC	100.00%	\$ 398	\$ 398	15
16	V	21	OFFICE EXPENSE		DOUBLE YOU REALTY, LLC		44	44	16
17	V	26	INSURANCE		DOUBLE YOU REALTY, LLC		626	626	17
18	V	30	DEPRECIATION		DOUBLE YOU REALTY, LLC		4,902	4,902	18
19	V	32	INTEREST EXPENSE		DOUBLE YOU REALTY, LLC		7,261	7,261	19
20	V	33	REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC		8,589	8,589	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	21,228	DOUBLE YOU REALTY, LLC			(21,228)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 21,228			\$ 21,820	\$ * 592	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39



VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

Facility Name & ID Number      Atrium Health Care Center      #      0033977      Report Period Beginning:      01/01/05      Ending:      12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Howard Wengrow	Owner	Administrative	25.31%	See Attached	5.00	7.69%	Sal. Staycare	\$ 12,692	17-7	1
2	Jeff Webster	Owner	Administrative	25.31%	See Attached	25.00	38.46%	Sal. Staycare	63,462	17-7	2
3	Yeruchom Levovitz	Relative	Administrator	0.00%	N/A	40.00	100.00%	Salary	73,401	17-1	3
4	Shimon Webster	Relative	Asst. Admin.	0.00%	N/A	6.75	100.00%	Salary	11,846	17-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 161,401		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number     Atrium Health Care Center     #   0033977   Report Period Beginning:     01/01/05     Ending:   12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office  
or parent organization costs? (See instructions.)     YES ☐     NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_  
Street Address \_\_\_\_\_  
City / State / Zip Code \_\_\_\_\_  
Phone Number (     ) \_\_\_\_\_  
Fax Number (     ) \_\_\_\_\_

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number     Atrium Health Care Center     #   0033977   Report Period Beginning:     01/01/05     Ending:   12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)     YES ☒     NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization     STAYCARE MANAGEMENT, LTD.  
Street Address     3737 W ARTHUR AVENUE  
City / State / Zip Code     LINCOLNWOOD, IL 60712  
Phone Number     (847) 679-2121  
Fax Number     (847) 679-2122

	1 Schedule V Line Reference	2  Item	3  Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5  Number of Subunits Being Allocated Among	6  Total Indirect Cost Being Allocated	7  Amount of Salary Cost Contained in Column 6	8  Facility Units	9  Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	179,651	5	\$ 7,111	\$	52,968	\$ 2,097	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	179,651	5	11,821		52,968	3,485	2
3	17	ADMIN. SAL.-NON OWNER	PATIENT DAYS	179,651	5	101,183	101,183	52,968	29,833	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	179,651	5	7,117		52,968	2,098	4
5	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	179,651	5	949		52,968	280	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	179,651	5	198,942	169,197	52,968	58,656	6
7	24	SEMINARS	PATIENT DAYS	179,651	5	2,115		52,968	624	7
8	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	179,651	5	7,399		52,968	2,181	8
9	26	INSURANCE	PATIENT DAYS	179,651	5	6,610		52,968	1,949	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	179,651	5	95,966		52,968	28,294	10
11	32	INTEREST	PATIENT DAYS	179,651	5	1,350		52,968	398	11
12	34	BUILDING RENT	PATIENT DAYS	179,651	5	72,000		52,968	21,228	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	179,651	5	24,120		52,968	7,111	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 536,683	\$ 270,380		\$ 158,233	25

Facility Name & ID Number     Atrium Health Care Center     #   0033977   Report Period Beginning:     01/01/05     Ending:   12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)     YES ☒     NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization     STAYCARE MANAGEMENT, LTD.  
Street Address     3737 W ARTHUR AVENUE  
City / State / Zip Code     LINCOLNWOOD, IL 60712  
Phone Number     (847) 679-2121  
Fax Number     (847) 679-2122

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIET. COMP - S. WEBSTER	AVG. HOURS WORKED	35	1	10,604	10,604			1
2	6	MAINT. COMP. - NON-OWNER	AVG. HOURS WORKED	40	5	26,310	26,310	12	7,757	2
3	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	35	1	1,445				3
4	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	5	3,267		12	963	4
5	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	5	165,000	165,000	5	12,692	5
6	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	65	5	165,000	165,000	25	63,462	6
7	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	5	10,765		5	828	7
8	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	65	5	10,641		25	4,093	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 393,032	\$ 366,914		\$ 89,795	25

Facility Name & ID Number     Atrium Health Care Center     #   0033977   Report Period Beginning:     01/01/05     Ending:   12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)     YES ☒     NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization     DOUBLE YOU REALTY, LLC  
Street Address     3737 W. ARTHUR AVENUE  
City / State / Zip Code     LINCOLNWOOD, IL 60712  
Phone Number     (847) 679-2121  
Fax Number     (847) 679-2122

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	179,651	5	\$ 1,350	\$	52,968	\$ 398	1
2	21	OFFICE EXPENSE	PATIENT DAYS	179,651	5	150		52,968	44	2
3	26	INSURANCE	PATIENT DAYS	179,651	5	2,123		52,968	626	3
4	30	DEPRECIATION	PATIENT DAYS	179,651	5	16,627		52,968	4,902	4
5	32	INTEREST EXPENSE	PATIENT DAYS	179,651	5	24,628		52,968	7,261	5
6	33	REAL ESTATE TAXES	PATIENT DAYS	179,651	5	29,131		52,968	8,589	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 74,009	\$		\$ 21,820	25

Facility Name & ID Number    Atrium Health Care Center                      #    0033977    Report Period Beginning:            01/01/05            Ending:    12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)                      YES ☐                      NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_  
Street Address \_\_\_\_\_  
City / State / Zip Code \_\_\_\_\_  
Phone Number (    ) \_\_\_\_\_  
Fax Number (    ) \_\_\_\_\_

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25



Facility Name & ID Number     Atrium Health Care Center     #   0033977   Report Period Beginning:     01/01/05     Ending:   12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)     YES ☐     NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number    Atrium Health Care Center                      #    0033977    Report Period Beginning:            01/01/05            Ending:    12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)                      YES ☐                      NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_  
Street Address \_\_\_\_\_  
City / State / Zip Code \_\_\_\_\_  
Phone Number (    ) \_\_\_\_\_  
Fax Number (    ) \_\_\_\_\_

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1					\$	\$			1
	2									2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$	25

Facility Name & ID Number    Atrium Health Care Center                      #    0033977    Report Period Beginning:                      01/01/05                      Ending:    12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office  
or parent organization costs? (See instructions.)                      YES ☐                      NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number     Atrium Health Care Center     #   0033977   Report Period Beginning:     01/01/05     Ending:   12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)     YES ☐     NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number     Atrium Health Care Center     #   0033977   Report Period Beginning:     01/01/05     Ending:   12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office  
or parent organization costs? (See instructions.)     YES ☐     NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_  
Street Address \_\_\_\_\_  
City / State / Zip Code \_\_\_\_\_  
Phone Number (     ) \_\_\_\_\_  
Fax Number (     ) \_\_\_\_\_

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	Allocated From Double You		X	Mortgage - MB Financial			\$				\$	7,261	1	
2	Allocated From Atrium Part.		X	Mortgage - MB Financial				1,281,668				91,528	2	
3													3	
4													4	
5	See Supplemental Schedule												5	
	Working Capital													
6	Due on Insurance		X	Prepaid Insurance				150,484				3,708	6	
7	Allocated From Staycare		X									398	7	
8	See Supplemental Schedule												8	
9	TOTAL Facility Related						\$	1,432,152				\$	102,895	9
	B. Non-Facility Related*													
10	Interest Income		X									(7,726)	10	
11	Parking Income		X									(4,475)	11	
12													12	
13	See Supplemental Schedule												13	
14	TOTAL Non-Facility Related						\$					\$	(12,201)	14
15	TOTALS (line 9+line14)						\$	1,432,152				\$	90,694	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							\$	\$			\$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							\$	\$			\$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

## B. Real Estate Taxes

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**SEE ACCOUNTANTS' COMPILATION REPORT**



IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Atrium Health Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0033977

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
			Tax
Tax Index Number	Property Description	Total Tax	Applicable to Nursing Home
1. 11-32-105-007-0000	Long Term Care Property	\$ 88,010.31	\$ 88,010.31
2. 11-32-105-006-0000	Long Term Care Property	\$ 45,980.84	\$ 45,980.84
3. 11-32-105-008-0000	Long Term Care Property	\$ 45,691.58	\$ 45,691.58
4. 11-32-105-005-0000	Long Term Care Property	\$ 3,381.97	\$ 3,381.97
5. 10-35-329-014-0000	Home Office	\$ 29,130.80	\$ 8,588.88
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 212,195.50	\$ 191,653.58

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Atrium Health Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0033977

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
			Tax
Tax Index Number	Property Description	Total Tax	Applicable to Nursing Home
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

42,313

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

3

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	26,895	1972	\$124,712	1
2	Allocated From Double You		2003	14,742	2
3	TOTALS	26,895		\$139,454	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1		2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$		4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Various			1972	50,343		20				9	
10	Various			1974	12,941		20				10	
11	Various			1977	46,500		20				11	
12	Various			1978	23,362		20				12	
13	Various			1979	11,676		20			1,354	13	
14	Various			1980	12,652		20			580	14	
15	Various			1981	4,095		20			393	15	
16	Various			1982	1,310		20			1,310	16	
17	Various			1989	42,200		20	2,110	2,110	28,414	17	
18	Various			1992	16,375		20	819	819	10,204	18	
19	Various			1993	26,090		20	1,305	1,305	14,738	19	
20	Various			1995	32,183		20	1,610	1,610	16,313	20	
21	Various			1996	71,604		20	3,581	3,581	34,311	21	
22	Various			1997	52,684		20	2,636	2,636	22,773	22	
23	Various			1998	131,108		20	6,557	6,557	50,140	23	
24	Various			1999	15,353		20	769	769	5,051	24	
25	Various			2000	71,157		20	2,656	2,656	16,059	25	
26	Various			2001	13,010		20	652	652	3,044	26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)	919,825	114,375		26,504	(87,871)	680,870	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)	147,440	3,613		3,939	326	11,524	68
69	Financial Statement Depreciation		23,617			(23,617)		69
70	TOTAL (lines 4 thru 69)	\$ 1,701,908	\$ 141,605		\$ 53,138	\$ (88,467)	\$ 897,078	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$1,701,908	\$141,605		\$53,138	\$(88,467)	\$897,078	1
2	Phone System	2002	536		20	54	54	205	2
3	Install Control Cabinet	2002	923		20	92	92	346	3
4	Phone System	2002	510		20	51	51	187	4
5	Telephone Service	2002	744		20	74	74	267	5
6	Pc Motor	2002	1,217		20	122	122	416	6
7	Ceiling	2002	741		20	74	74	278	7
8	Refrigerant	2002	888		20	89	89	303	8
9	Dble-Blwr W	2002	527		20	53	53	180	9
10	Phone System	2002	760		20	76	76	266	10
11	Coridor Bumpers	2003	5,861		20	586	586	1,661	11
12	Wallcoverings	2003	6,332		20			6,332	12
13	Lights	2003	4,965		20	497	497	1,283	13
14	Fence	2003	8,145		20	543	543	1,403	14
15	Nurses Staition	2003	6,010		20	601	601	1,553	15
16	Security System	2003	6,500		20	929	929	2,399	16
17	Door System	2003	6,379		20	638	638	1,648	17
18	Hvac	2003	1,820		20	91	91	265	18
19	Paint	2003	917		20	46	46	134	19
20	Hvac	2003	1,012		20	51	51	139	20
21	Hvac	2003	828		20	41	41	114	21
22	Hvac	2003	907		20	45	45	117	22
23	Elevator Repair	2003	635		20	32	32	82	23
24	Paint	2003	643		20	32	32	80	24
25	Alarm	2003	723		20	36	36	84	25
26	Security Door Device	2003	987		20	49	49	107	26
27	Patient Rooms Remodel	2003	7,497		20	375	375	968	27
28	Elevator Improvment	2004	2,880		20	288	288	432	28
29	Parts For Heater Repair	2004	1,092		20	55	55	109	29
30	Interior Design	2004	950		20	48	48	87	30
31	Parts For Heater Repair	2004	1,027		20	51	51	77	31
32	Main Entrance Sliding Door Repair	2004	1,399		20	70	70	99	32
33	Phone System	2005	5,719		20	286	286	286	33
34	TOTAL (lines 1 thru 33)		\$1,781,982	\$141,605		\$59,213	\$(82,392)	\$918,985	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$1,781,982	\$141,605		\$59,213	\$(82,392)	\$918,985	1
2	Used Generator	2005	6,000		20	275	275	275	2
3	Signs	2005	2,568		20	214	214	214	3
4	Fire Suppression System	2005	483		20	46	46	46	4
5	Water Heater	2005	7,112		20	356	356	356	5
6	Surveillance Video System	2005	2,329		20	55	55	55	6
7	Cubical Curtains	2005	2,816		20	141	141	141	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$1,803,290	\$141,605		\$60,300	\$(81,305)	\$920,072	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$1,803,290	\$141,605		\$60,300	\$(81,305)	\$920,072	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$1,803,290	\$141,605		\$60,300	\$(81,305)	\$920,072	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$1,803,290	\$141,605		\$60,300	\$(81,305)	\$920,072	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$1,803,290	\$141,605		\$60,300	\$(81,305)	\$920,072	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$1,803,290	\$141,605		\$60,300	\$(81,305)	\$920,072	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$1,803,290	\$141,605		\$60,300	\$(81,305)	\$920,072	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$1,803,290	\$141,605		\$60,300	\$(81,305)	\$920,072	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$1,803,290	\$141,605		\$60,300	\$(81,305)	\$920,072	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$1,803,290	\$141,605		\$60,300	\$(81,305)	\$920,072	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$1,803,290	\$141,605		\$60,300	\$(81,305)	\$920,072	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)  
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$1,803,290	\$141,605		\$60,300	\$(81,305)	\$920,072	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$1,803,290	\$141,605		\$60,300	\$(81,305)	\$920,072	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$1,803,290	\$141,605		\$60,300	\$(81,305)	\$920,072	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$1,803,290	\$141,605		\$60,300	\$(81,305)	\$920,072	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$1,803,290	\$141,605		\$60,300	\$(81,305)	\$920,072	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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17									17
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20									20
21									21
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$1,803,290	\$141,605		\$60,300	\$(81,305)	\$920,072	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				1972	\$ 574,854	\$ 114,375	33	\$ 26,504	\$ (87,871)	\$ 680,870	4
5				1972	344,971		20				5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$919,825	\$114,375		\$26,504	\$(87,871)	\$680,870	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)											
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	Allocated From Double You		2003	2003	\$ 140,913	\$ 3,613	20	\$ 3,613	\$	\$ 10,689	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated From Staycare		2003		6,527		20	326	326	835	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$147,440	\$3,613		\$3,939	\$326	\$11,524	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 131,948	\$ 1,289	\$ 19,345	\$ 18,056	10	\$ 68,709	71
72	Current Year Purchases	2,449		163	163	10	163	72
73	Fully Depreciated Assets	337,539				10	337,539	73
74								74
75	TOTALS	\$ 471,936	\$ 1,289	\$ 19,508	\$ 18,219		\$ 406,411	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated From Staycare	2003	\$ 8,254	\$	\$ 1,651	\$ 1,651	5	\$ 4,127	76
77										77
78										78
79										79
80	TOTALS			\$ 8,254	\$	\$ 1,651	\$ 1,651		\$ 4,127	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,422,934	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 142,894	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 81,459	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (61,435)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,330,610	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized  
by the length of the lease
- 
- 

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
- 
- \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☒ NO

16. Rental Amount for movable equipment: \$
- Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated From Staycare		\$	\$ 7,111	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 7,111	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES  
☒ NO

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM  
IN OTHER FACILITY  
COMMUNITY COLLEGE  
HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM  
IN OTHER FACILITY  
HOURS PER CNA

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.  
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 9,456	\$		\$ 9,456	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			640			640	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			81,225			81,225	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				51,109		51,109	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						210		210	13
14	TOTAL			\$		\$ 91,321	\$ 51,319		\$ 142,640	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 734,161	\$ 734,175	1
2	Cash-Patient Deposits	70,467	70,467	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	863,506	863,506	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	169,969	169,969	6
7	Other Prepaid Expenses	950	950	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	(5,881)	(5,881)	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,833,172	\$ 1,833,186	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		260,000	13
14	Buildings, at Historical Cost		4,460,623	14
15	Leasehold Improvements, at Historical Cost	381,414	381,414	15
16	Equipment, at Historical Cost	203,327	683,327	16
17	Accumulated Depreciation (book methods)	(320,526)	(2,215,917)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		31,777	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 264,215	\$ 3,601,224	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,097,387	\$ 5,434,410	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 92,240	\$ 92,279	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	69,403	69,403	28
29	Short-Term Notes Payable	150,484	150,484	29
30	Accrued Salaries Payable	158,491	158,491	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	188,557	188,557	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	4,559	4,559	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	67,453	35,569	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 731,187	\$ 699,342	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,281,668	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,281,668	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 731,187	\$ 1,981,010	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,366,200	\$ 3,453,400	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,097,387	\$ 5,434,410	48



XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,686,266	1
2	Restatements (describe):		2
3	Prior Year Depreciation Adjustment	543	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,686,809	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	959,391	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,280,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (320,609)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,366,200	24 *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note:** This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 5,771,333	1
2	Discounts and Allowances for all Levels	(236,456)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,534,877	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	252,591	6
7	Oxygen	1,740	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 254,331	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	53,940	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,372	19
20	Radiology and X-Ray		20
21	Other Medical Services	34,933	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 91,245	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	7,726	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 7,726	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	7,160	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 7,160	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,895,339	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,056,719	31
32	Health Care	1,791,689	32
33	General Administration	1,078,813	33
	<b>B. Capital Expense</b>		
34	Ownership	778,487	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	142,640	35
36	Provider Participation Fee	87,600	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,935,948	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	959,391	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 959,391	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,004	2,230	\$ 78,088	\$ 35.02	1
2	Assistant Director of Nursing	1,441	1,603	52,059	32.48	2
3	Registered Nurses	11,949	12,837	307,703	23.97	3
4	Licensed Practical Nurses	21,930	24,084	509,151	21.14	4
5	CNAs & Orderlies	47,014	50,389	443,422	8.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,184	4,926	45,514	9.24	8
9	Activity Director	1,836	1,988	17,616	8.86	9
10	Activity Assistants	5,437	5,777	42,289	7.32	10
11	Social Service Workers	6,597	7,045	80,608	11.44	11
12	Dietician					12
13	Food Service Supervisor	1,849	2,025	33,318	16.45	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,498	22,521	206,966	9.19	15
16	Dishwashers					16
17	Maintenance Workers	2,156	2,323	35,125	15.12	17
18	Housekeepers	23,464	25,620	216,234	8.44	18
19	Laundry	7,329	7,856	65,044	8.28	19
20	Administrator	2,177	2,397	73,401	30.62	20
21	Assistant Administrator	351	387	11,846	30.61	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,227	4,291	30,167	7.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,772	4,053	109,193	26.94	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	168,215	182,352	\$ 2,357,744 *	\$ 12.93	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 9,943	01-03	35
36	Medical Director	Monthly	11,050	09-03	36
37	Medical Records Consultant	Monthly	11,083	10-03	37
38	Nurse Consultant	Monthly	10,178	10-03	38
39	Pharmacist Consultant	Monthly	2,880	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	7	320	10a-03	43
44	Activity Consultant	37	1,947	11-03	44
45	Social Service Consultant	74	3,922	12-03	45
46	Other(specify)				46
47	Religious Services		3,800	01-03	47
48					48
49	TOTAL (lines 35 - 48)	117	\$ 55,123		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

<b>Facility Name &amp; ID Number</b>	<b>Atrium Health Care Center</b>
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## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			
Name	Function	%	Amount
Yeruchom Levovitz	Administrator	0	\$ 73,401
Shimon Webster	Asst. Admin.	0	11,846
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 85,247
B. Administrative - Other			
Description			Amount
Staycare Management Fees			\$ 244,800
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 244,800
C. Professional Services			
Vendor/Payee	Type		Amount
Frost, Ruttenburg & Rothblatt	Accounting Fees	\$	20,459
Personnel Planners	Unemployment Consulting		1,219
MDI Technologies	Computer Expense		2,725
See Attachment	Legal Fees		31,070
Keylex	Computer Expense		1,000
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 56,473
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	53,904
Unemployment Compensation Insurance			33,202
FICA Taxes			172,691
Employee Health Insurance			89,331
Employee Meals			31,726
Illinois Municipal Retirement Fund (IMRF)*			
Union Pension Expense			20,529
Employee Benefits			1,468
Head Tax Expense			4,810
401K Employer			3,705
TOTAL (agree to Schedule V, line 22, col.8)			\$ 411,366
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	1,990
Advertising: Employee Recruitment			11,334
Health Care Worker Background Check (Indicate # of checks performed 20 )			200
Licenses & Fees			3,079
ILCLTC			9,327
Yellow Page Advertising			5,863
Allocation Staycare Mgmt.			280
Less: Public Relations Expense ( ) Non-allowable advertising ( ) Yellow page advertising (5,863)			
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 26,210
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			2,101
Allocated From Staycare			624
Entertainment Expense ( )			
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	2,725

**\* Attach copy of IMRF notifications**  
**SEE ACCOUNTANTS' COMPILATION REPORT**

**\*\*See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union?

Yes

(2) Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

ILCLTC \$11,600

(3) Did the nursing home make political contributions or payments to a political action organization?

Yes

If YES, have these costs been properly adjusted out of the cost report?

Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A

(5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$4,237

Line10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

(9) Are you presently operating under a sublease agreement?

YESXNO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YESXNO

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$87,600

This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$31,726

Has any meal income been offset against related costs?

No

Indicate the amount.

\$N/A

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

None

d. Have vehicle usage logs been maintained?

N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$N/A

(17) Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

N/A

The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?

N/A

If no, please explain.

N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes

(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?

Yes

Attach invoices and a summary of services for all architect and appraisal fees.